

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>445223</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/11/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>RENAISSANCE TERRACE CARE AND REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>257 PATTON LANE HARRIMAN, TN 37748</b>
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F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain a physician's order to transport to a hospital for one resident (#7) of sixteen sampled residents.</p> <p>The findings included:</p> <p>Medical record review revealed Resident #7 was admitted to the facility on January 17, 2007, with diagnoses including Schizophrenia. Medical record review of a psychologist's progress note dated December 14, 2010, revealed, "...will consider hospitalization...for beh (behavior) secondary Thought disturbance/labile mood..."</p> <p>Medical record review of a nurse's note dated December 17, 2010, at 10:20 a.m., revealed, "Res (resident) left for (hospital) behavior unit..."</p> <p>Medical record review of a nurse's note dated December 30, 2010, revealed the resident returned to the facility from the hospital.</p> <p>Medical record review revealed no physician's order regarding transport and/or evaluation/treatment of Resident #7 at a hospital on December 17, 2010.</p> <p>Interview with the director of medical records on March 8, 2010, at 1:32 p.m., in a conference room, revealed the facility was unable to locate a physician's order to send the resident to a</p>	F 281	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, <b>Renaissance Terrace Care &amp; Rehabilitation Center</b> does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p><b>F281</b></p> <p>1. Resident #7's physician was notified of transport to the hospital on December 17, 2010 by the unit manager.</p> <p>2. Other discharged/transferred resident charts were reviewed for transport orders by the Health Information Manager and the Director of Nursing Service completed on March 24, 2011. Any identified issues were communicated to the physician by a licensed nurse by March 25, 2011.</p>	3/29/11

RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Robert Duff</i>	TITLE <i>ADMINISTRATOR</i>	(X6) DATE <i>3/25/11</i>
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efficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued im participation.

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F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain a physician's order to transport to a hospital for one resident (#7) of sixteen sampled residents.</p> <p>The findings included:</p> <p>Medical record review revealed Resident #7 was admitted to the facility on January 17, 2007, with diagnoses including Schizophrenia. Medical record review of a psychologist's progress note dated December 14, 2010, revealed, "...will consider hospitalization...for beh (behavior) secondary Thought disturbance/labile mood..."</p> <p>Medical record review of a nurse's note dated December 17, 2010, at 10:20 a.m., revealed, "Res (resident) left for (hospital) behavior unit..."</p> <p>Medical record review of a nurse's note dated December 30, 2010, revealed the resident returned to the facility from the hospital.</p> <p>Medical record review revealed no physician's order regarding transport and/or evaluation/treatment of Resident #7 at a hospital on December 17, 2010.</p> <p>Interview with the director of medical records on March 8, 2010, at 1:32 p.m., in a conference room, revealed the facility was unable to locate a physician's order to send the resident to a</p>	F 281	<p>3. Re-education completed on March 27, 2011, was provided for the licensed staff by the Director of Nursing Services and Staff Development Coordinator regarding obtaining and writing an order from the physician prior to resident transport and/or discharge.</p> <p>4. Any transported or discharged residents medical record will be reviewed weekly by the Director of Nursing Services or Nursing Supervisors for 1 month and monthly for three months. The findings will be presented by the Director of Nursing in the monthly Performance Improvement (PI) Meeting for further recommendations. The Performance Improvement Committee includes the Administrator, Assistant Administrator, Medical Director, Director of Nursing Services, Assistant Directors of Nursing, Social Services Director, Activities Director, Housekeeping Supervisor, Nutritional Service Director, Clinical Case Manager, MDS Coordinator, Infection Control Nurse, Maintenance Director, and Pharmacy Consultant.</p>	3/29/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

A deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	Continued From page 1 hospital on December 17, 2010.	F 281		
F 425 SS=D	<p>Telephone interview with the administrator on March 11, 2011, at 3:45 p.m., confirmed the facility failed to obtain a physician's order to transport and/or evaluate/treat Resident #7 at a hospital on December 17, 2010.</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to provide pharmaceutical services to ensure the accurate dispensing and administering of controlled medications for one resident (#1) of sixteen sampled residents.</p>	F 425	<p><b>F425</b></p> <p>1. The pharmacist and physician were notified by the Administrator and the Director of Nursing on March 12, 2011 regarding resident #1's medical record recapitulation summary, controlled substance record and medication regimen.</p> <p>2. Other resident's medical records were reviewed by the nursing management team on March 12, 2011, to compare physician orders with the controlled substance record. Pharmacy staff will complete a review by March 28, 2011 of other resident's physician orders, medication administration record and pharmacy labels. Any identified issues will be corrected and physician notification will occur by March 28, 2011.</p>	3/29/11

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F 425	<p>Continued From page 2</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on November 15, 2010, with diagnoses including Arthritis and Chronic Osteomyelitis of Left Lower Extremity. Medical record review of a physician's order dated November 13, 2010, revealed, "...Valium (anti-anxiety medication)(Diazepam) 5 mg (milligram) tablet by mouth...Every eight hours Everyday..." Medical record review of a physician's order dated January 12, 2011, revealed, "Hydrocodone-Acetaminophen (narcotic pain medication) 10-325 by mouth...Everyday, 0000 0400 0800 1200 1600 2000 (12:00 a.m. 4:00 a.m. 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m.), Give one tab (tablet every 4 hours routinely while awake." Medical record review of recapitulation (summary) orders dated January and February, 2011, revealed the orders for the medications remained current physician orders. Continued review revealed the resident did not have orders for PRN (as needed) Valium or Hydrocodone.</p> <p>Medical record review of an Individual Patient's Controlled Substances Record dated January 30, 2011, through February 9, 2011, revealed, "Diazepam 5 mg tablet...Take 1 tab (tablet) by mouth three times daily and take 1 tab by mouth three times daily as needed..." Continued review revealed the medication was not signed out on February 6th or 9th, 2011, at 12:00 a.m. and no medication was used at times other than 12:00 a.m., 8:00 a.m., and 4:00 p.m.</p> <p>Medical record review of an Individual Patient's Controlled Substances Record dated February 11, 2011, revealed, "Hydrocodone/Acetamin</p>	F 425	<p>3. Re-education for licensed nurses was provided by the Director of Nursing Services and Staff Development Coordinator on physician order verification, transcribing orders, completing the medication administration record and controlled substance record. This re-education was completed on March 19, 2011. The facility pharmacist was re-educated on March 26, 2011, by the pharmacy supervisor, on medication regimen, reviews, and pharmacy medication labeling and identifying pharmacist that completes review on the record.</p> <p>4. Review of the medication administration record and controlled substance records for signatures will be completed by the Director of Nursing or Nursing Supervisors weekly for 1 month and monthly for 3 months. The Director of Nursing or Nursing Supervisors will review the medication regimen reviews for pharmacist name monthly for 3 months. The findings will be presented by the Director of Nursing monthly for three months in the monthly Performance Improvement (PI) Meeting for further recommendations. The pharmacy</p>	

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F 425	<p>Continued From page 3</p> <p>10-325 tablet...1 tab by mouth every 4 hours as needed for pain..." Continued review revealed the medication was signed out on February 13, 2011, the time was illegible, a line drawn through the entry, and the count remained the same. Continued review revealed the medication was not signed out on February 13 or 14, 2011, at 4:00 a.m.</p> <p>Medical record review of a Medication Regimen Reviews dated February 4, 2011, revealed no irregularities were identified and failed to identify the pharmacist's name.</p> <p>Telephone interview with the Interim Director of Nursing on March 11, 2011, at 1:25 p.m., revealed the facility did not have a controlled substance record for the resident's routine pain or anxiety medication and the facility had used mislabeled Individual Patient's Controlled Substances Records for the resident's pain and anxiety medication.</p> <p>Telephone interview with the administrator on March 11, 2011, at 3:35 p.m., revealed the pharmacy consultant was notified of irregularities regarding the resident's controlled medications on March 11, 2011, and the pharmacy consultant was unavailable for interview. Continued interview confirmed the facility's pharmacy consultant failed to provide pharmaceutical services required to ensure accurate dispensing and administration of controlled medications and provide consultation regarding provision of pharmacy services for Resident #1.</p>	F 425	<p>supervisor will review the finding of the facility pharmacy review for irregularities. The findings will be presented to the monthly Performance Improvement Committee for further recommendations. to ensure compliance with pain management. The Performance Improvement Committee includes the Administrator, Assistant Administrator, Medical Director, Director of Nursing Services, Assistant Directors of Nursing, Social Services Director, Activities Director, Housekeeping Supervisor, Nutritional Service Director, Clinical Case Manager, MDS Coordinator, Infection Control Nurse, Maintenance Director, and Pharmacy Consultant.</p>	3/29/11
F 514 SS=D	<p>C/O: #27415</p> <p>483.75(I)(1) RES</p> <p>RECORDS-COMPLETE/ACCURATE/ACCESSIB</p>	F 514		

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F 514	<p>Continued From page 4 LE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain a complete, accurate medical record for one resident (#1) of sixteen sampled residents.</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on November 15, 2010, with diagnoses including Arthritis and Chronic Osteomyelitis of Left Lower Extremity. Medical record review of a physician's order dated November 13, 2010, revealed, "...Valium (anti-anxiety medication)(Diazepam) 5 mg (milligram) tablet by mouth...Every eight hours Everyday..." Medical record review of a physician's order dated January 12, 2011, revealed, "Hydrocodone-Acetaminophen (narcotic pain medication) 10-325 by mouth...Everyday, 0000 0400 0800 1200 1600 2000 (12:00 a.m. 4:00 a.m. 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m.), Give one tab (tablet every 4 hours</p>	F 514	<p><b>F514</b></p> <p>1. The physician was notified by the Director of Nursing Service on March 12, 2011 of resident #1's controlled substance record and medication administration record.</p> <p>2. Other resident's medical records, medication administration records and controlled substance records were reviewed on March 24, 2011 by the nursing management team. No other residents were affected.</p> <p>3. Licensed nurses were re-educated by the Director of Nursing Services or Staff Development Coordinator on administering medications as ordered, documentation of administering medications and correct labeling of controlled substance records. This re-education was completed on March 28, 2011</p>	3/29/11

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F 514	<p>Continued From page 5</p> <p>rouinely while awake." Medical record review of recapitulation (summary) orders dated January and February, 2011, revealed the orders for the medications remained current physician orders.</p> <p>Medical record review of a Medication Administration Record (MAR) dated February, 2011, revealed Valium 5 mg was not initialed as administered on February 4, 5, and 6, 2011, at 12:00 a.m. Continued review revealed Hydrocodone-Acetaminophen 10-325 mg was initialed and circled (indicates not administered) on February 13 and 14, 2011, at 4:00 a.m. Medical record review revealed no documentation regarding an explanation for the circled nurse's initials.</p> <p>Medical record review of an Individual Patient's Controlled Substances Record dated January 30, 2011, through February 9, 2011, revealed, "Diazepam 5 mg tablet...Take 1 tab (tablet) by mouth three times daily and take 1 tab by mouth three times daily as needed..." Continued review revealed the medication was not signed out on February 6th or 9th, 2011, at 12:00 a.m. and no medication was used at times other than 12:00 a.m., 8:00 a.m., and 4:00 p.m.</p> <p>Medical record review of an Individual Patient's Controlled Substances Record dated February 11, 2011, revealed, "Hydrocodone/Acetamin 10-325 tablet...1 tab by mouth every 4 hours as needed for pain..." Continued review revealed the medication was signed out on February 13, 2011, the time was illegible and a line was drawn through the entry, and the count remained the same. Continued review revealed the medication was not signed out on February 13 or 14, 2011, at 4:00 a.m.</p>	F 514	<p>4. A review of medical records for completeness will be completed by the Health and Information Manager on 5 residents per week for 4 weeks, then monthly for 2 months. The Director of Nursing or Nursing Supervisor will complete a review of medication administration records and controlled substance records for correct labeling and documentation on 5 residents per week for 4 weeks, then monthly for 2 months. The findings will be presented by the Director of Nursing to the Performance Improvement (PI) Meeting for further recommendations. The Performance Improvement Committee includes the Administrator, Assistant Administrator, Medical Director, Director of Nursing Services, Assistant Directors of Nursing, Social Services Director, Activities Director, Housekeeping Supervisor, Nutritional Service Director, Clinical Case Manager, MDS Coordinator, Infection Control Nurse, Maintenance Director, and Pharmacy Consultant.</p>	3/29/11

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F 514	Continued From page 6  Telephone interview with the Interim Director of Nursing on March 11, 2011, at 1:25 p.m., revealed the facility did not have a controlled substance record for the resident's routine pain or anxiety medication. Continued interview revealed the facility had used mislabeled Individual Patient's Controlled Substances Records for the resident's pain and anxiety medication, and confirmed the facility had failed to maintain a complete, accurate medical record for Resident #1.  C/O: #27415	F 514		

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